Appendix 20e ▪ Client's Physicians and Other Health Professionals (Optional)

Client's Last Name	First Name	MI	MSSP #

NAME: SPECIALTY: ADDRESS:	MSSP Assessment Date Last seen by HP?	1	2	3	4
PHONE: MEDI-CAL PAYS? ☐ Yes ☐ No	MSSP Assessment Date Last seen by HP?	5	6	7	8

NAME: SPECIALTY: ADDRESS:	MSSP Assessment Date Last seen by HP?	1	2	3	4
PHONE: MEDI-CAL PAYS? ☐ Yes ☐ No	MSSP Assessment Date Last seen by HP?	5	6	7	8

NAME: SPECIALTY: ADDRESS:	MSSP Assessment Date Last seen by HP?	1	2	3	4
PHONE: MEDI-CAL PAYS? ☐ Yes ☐ No	MSSP Assessment Date Last seen by HP?	5	6	7	8